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ABSTRACT

Vietnam veterans from racial or ethnic minority groups have a "double minority" status; clinicians treating these veterans should distinguish between behaviors resulting from experiences in Vietnam and those due to experiences as members of minority groups. Post-Traumatic Stress Disorder (PTSD) affects an estimated 20% of all Vietnam veterans and has a wide range of physical and behavioral symptoms, some of which (high unemployment, low levels of education, alienation from the majority culture, feelings of anger at and oppression by authority, feelings of powerlessness, low self-esteem, high levels of violence and depression, high suicide rates, and high levels of alcohol/substance abuse) are similar to characteristics of some minority group members. Clinicians should avoid making a diagnosis on the basis of stereotypes of minorities or of Vietnam veterans, and should have a clear understanding of the causes and symptoms of PTSD and a good sense of their own biases and values. Both veterans and minority people have suffered discrimination and may be wary or hostile when seeking clinical services; clinicians should distinguish whether these attitudes are due to racial, cultural or experiential factors. Specific therapeutic interventions which have been used with minority Vietnam veterans include Rap Groups and linkages with traditional indigenous healers from minority communities. (MH)

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The Assessment of Post-Traumatic Stress Disorder Among Minority Vietnam Veterans

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ABSTRACT

Minority status for any specific group can be conferred on the basis of race, cultural and value differences for those of the majority society or on the basis of sharing a significant life experience. The latter is the case with Vietnam veterans as well as survivors of disasters and rape victims. This paper looks at the area of Post-Traumatic Stress Disorder as it effects Vietnam veterans, in general, and the difficulties associated with the diagnosis of PTSD in "minority" Vietnam veterans, e.g. Blacks, Hispanics, American Indians, Asian-Americans, Pacific Islanders, and Alaska Natives.

Minority status for any specific population group has usually been conferred on the basis of race and cultural and/or value differences from those of the majority society. American minority groups include Blacks, persons of Hispanic descent, American Indians/Alaska Natives, Asian-Americans, certain religious groups, Appalachian whites, and Pacific Islanders. While the members of these groups are often readily identifiable through physical, cultural, and demographic variables, there are people with minority status that are far less easy to identify. These people are those who share a unique, significant life experience and include, (but are not limited to) the following: victims of sexual/physical abuse, survivors of concentration camps and disasters, and Vietnam veterans (Horowitz, 1976). The minority status of Vietnam veterans, particularly those with "double minority" status by virtue of their racial/cultural backgrounds will be examined in this paper. Clinical, diagnostic, and therapeutic implications of post-traumatic stress disorder among minority veterans will be explored and suggestions for more viable treatment options will be presented.

The first area of focus for this paper will be of post-traumatic stress disorder (PTSD), its diagnosis and incidence among Vietnam veterans, in general. It is estimated that approximately 2.5 to three million men and women served in Vietnam. The exact breakdown, by race and/or ethnic group is not known although it appears that slightly more minority veterans saw combat,

by percentage, than their white counterparts. Of the men and women who served in Vietnam, it is estimated that 20% of all these veterans have some degree of post-traumatic stress disorder with this figure increasing to 40-60% among those who saw combat. If this is indeed the case, then approximately 700,000 - 800,000 Vietnam veterans experience PTSD and continue to have their lives affected in a variety of ways (Williams, 1980).

The incidence of PTSD among soldiers is not a new phenomena. The terms have changed from war to war, i.e. shell-shock, battle-fatigue, combat neurosis, PTSD; but the prolonged effects of war, or any other event, resulting from psychic trauma, remain the same (Bartzmeier, 1946). Only recently have these effects been more clearly deliniated and studied. In making a diagnosis of PTSD, the following criteria are evaluated (APA/1980):

A. A recognizable stressor that would be expected to evoke significant symptoms of distress in almost all individuals

B. Re-experiencing the traumatic event either by

(1) recurrent and intrusive recollections of the event; or
(2) recurrent dreams of the event; or
(3) suddenly acting or feeling as if the traumatic event were occurring because of an association with an environmental or ideational stimulus

C. Numbing of responsiveness to, or involvement with, the external world, beginning some time after the traumatic event(s) as shown by either

(1) markedly diminished interest in one or more significant activities; or
(2) feelings of detachment from others; or

(3) marked constriction of affective responses

D. At least two of the following (not present prior to the traumatic event)

(1) hyperalterness or exaggerated startle response;
(2) initial, middle, or terminal sleep disturbance;
(3) guilt about surviving when others have not, or about behavior required to achieve survival;
(4) avoidance of activities that arouse recollection of the traumatic event;
(5) memory impairment or trouble concentrating;
(6) intensification of symptoms by exposure to events that symbolize or resemble the traumatic event.

Wilson and Krauss(1982) have identified several dimensions of PTSD which are consistent with the clinical picture presented by many Vietnam veterans. These dimensions include: (1) depression, identity confusion; (2) physical symptoms, memory impairment; (3) stigmatization, alienation, cynicism; (4) sensation seeking, authority conflict; (5) anger, rage; (6) intrusive imagery of Vietnam, and (7) intimacy conflict. In addition to the above, many Vietnam veterans complain of nightmares, feelings of being "out of control," of being "exploited," and of "not fitting in." Substance abuse is often seen as are suicidal/homicidal ideations (LaCoursiere, Godfry, and Ruby, 1980).

Other concerns commonly expressed center around marital, social, and employment stability. An inability to share their war experiences, difficulty in trusting and fear of "being close" often result in marital problems or divorce and in social isolation. Anger and resentment over their nonveteran age-mates

employment and financial success is commonly coupled with the veterans' feelings of low self-esteem due to their difficulty in gaining and maintaining employment.

Rather than focusing on a single symptom or only on DSM-III criteria, the clinician needs to have a clear picture of the veterans' social, employment and psychological functioning. Such a holistic view becomes even more important when the compounding factors of racial and/or cultural differences are introduced (Jackson, 1978). For a better understanding of the possible effects of these factors contrast the clinical picture of PTSD in Vietnam veterans with the following description of dynamics commonly seen among people in minority groups (Fiman, Borus, & Stanton, 1975; Howe, 1977; Leventman & Camacho, 1974).

Many minority groups face high unemployment levels, lower levels of education, feelings of anger at, and oppression by authority and people of the majority culture; higher levels of violence and depression, feelings of low self-esteem, higher suicide rates and higher rates of alcohol/substance abuse (Fredericks, 1973; Jacobs, Landau, Pell, 1973; French, 1976; Metcalf, 1976). By virtue of their smaller numbers, they often have limited political power and are the victims of negative stereotypes.

A distrust of nonminority people and reluctance to share their issues and concerns with "outsiders" are commonly expressed. A sense of "not fitting in" with the majority culture and a lack

of personal and/or social power are frequently stated. The denigration of culture and values by the majority society and ambivalence to one's own group is also common (French, 1976; Metcalf, 1976; Willie, Kramer & Brown, 1973).

Such a comparison highlights the similarities between the clinical picture of Vietnam veterans with PTSD and the social/psychological experiences of members of many minority groups. For Vietnam veterans of minority racial/cultural backgrounds, the similarities described above may have serious ramifications in the accurate diagnosis of PTSD. As many minorities are often understood only in terms of commonly held stereotypes, so has this been true for Vietnam veterans.

The typical stereotype for Vietnam veterans, until recently, has been one of a "drug-using, kill-crazy, unemployed, unpredictable, psychotic" male who is a "walking time bomb" trying to "get something from the government because they're too lazy to work." If the clinician is making a diagnosis on the basis of stereotypes, be it racial/cultural or similar to the one described above, it is likely the critical clinical evidence for diagnosing PTSD will be missed. A presentation of specific examples may be useful in clarifying the ways cultural variables might influence the clinical picture of PTSD. These examples are generalities intended to aid in identification of cultural variables and caution should be exercised to not miss crucial individual differences.

Frequently clinicians perceive minority Vietnam veterans as suspicious and very cautious, perhaps shading into paranoia, what is not clear is whether the etiology of these concerns is due to racial, cultural or experiential factors, as in PTSD. Many people of minority background have experienced discrimination in a wide range of areas from getting a job to causual social situations. They have learned to be alert, cautious and sensitive to such discrimination as a survival skill much as the Vietnam veteran learned to be hyperalert and vigilant to survive his war experience.

Rage, anger and hostility are also commonly seen in minority Vietnam veterans seeking services. Many minority people may have hostility towards people of the "majority" culture, anger or rage over discrimination they have faced as a result of being a member of a minority group, and, again, may use such feelings as a survival skill to keep nonminority group members at a "safe" emotional distance. Often professionals, civilians in positions of authority and higher ranking military personnel are white and may not have an awareness of, or sensitivity to, minority experiences and concerns(Bourne, 1972; Caputo, 1977).

By virtue of small members, both in civilian life and in the military hierarchy, minority people have not often had political power or been in positions to have control over decisions which affect their lives in very real ways. Such feelings of helplessness are hypothesized to lead to depression, anger, and

isolation(Miller & Seligman, 1975). These are also concerns clinically presented by minority Vietnam veterans and may be indicative of PTSD.

As with suspiciousness and vigilance, anger and isolation served as a very real survival mechanism for Vietnam veterans, not so much while they were in Vietnam but upon homecoming. Anger, if used psoitively, can be a powerful motivating force for making change while, for many veterans, isolation has been a way of "protecting" others and themselves from such anger "getting out of control." The problem has often been, however, that many veterans have felt impotent in their anger, isolated by Vietnam veteran status and become depressed, suicidal or substance abusers. The isolation experienced by may Vietnam veterans is physical but often accompanied by an emotional aloneness. This is a feeling that they cannot let anyone in close for fear of either being rejected by others or simply of being "different" from people around them.

The pattern described above is frequently seen in young men, particularly, from minority cultures, with a familiar example being both veterans and nonveteran American Indians(LaDue, 1982; Pollock & Shore, 1980). Therefore, in working with minority Vietnam veterans who present clinically with anger, hostility, depression, isolation and/or patterns of alcohol/drug abuse, the clinician needs to be careful in <u>clearly</u> understanding both the

veterans cultural and experiential background as well as their Vietnam experiences.

The experience of psychic trauma, stress and resultant consequences appear to be a fairly universal phenomena(Rahe, 1969). What is not always understood is that psychic trauma can result from a very wide range of life experiences from being in a war to being continually discriminated against by virtue of one's racial/cultural background. Indeed, for many, if not most, minority people in America, their group histories have included violence from and towards the majority society, e.g. the racial riots of the 1960's, the American Indian Movements battles with the FBI in 1972, and the "Zoot Suit" riots of the 1940's(Landon,).

The minority Vietnam veteran has often dealt with discrimination as part of their life experience. Coupled, however, with the additional effects of war, the survival skills learned prior to military service may simply not be either sufficient to deal with the added trauma or may become so exaggerated as to appear, at least clinically, as being part of a character disorder or other psychological problem rather than the actuality of PTSD. Therefore, clinicians must be extremely diligent is probing for the other manifestations of PTSD such as survivor guilt, intrusive thoughts, memory impairment or difficulty in concentrating and diminished interest in one or more significant activities (Wilson, 1981).

So far this paper has presented the diagnostic criteria for PTSD and its clinical manifestations which may also be a result of the veteran being from a minority group. To avoid the common error of using stereotypes which may be misleading, general concerns have been outlined to give the clinician a framework of awareness from which to make a more accurate assessment of the etiology of clinical concerns be it from the veterans' minority status or due to PTSD. What might now be useful in a review of specific therapeutic interventions used with minority Vietnam veterans.

The Combat Rap Group has been a mainstay program such as the Readjustment Counseling Services provided through the Vet Centers. Rap Groups comprised only of members of one minority group have been used with the intent being to have group members understand their Vietnam and other experiences not only in terms of possible PTSD but also from a racial/cultural viewpoint(Jones, 1983). Rap Groups held in other Vet Centers frequently have combat rap groups comprised of veterans from a diversity of ethnic/racial groups. Through training, group leaders have been encouraged to explore the possible racial/cultural experiences in the course of the group.

A less used but very vital therapeutic tool has been the linkage of formal programs such as Readjustment Counseling Services with "traditional" indigenous healers from the minority community

(Holmes, 1982; Willard & LaDue, 1981). A good example of such linkage was the American Indian Vietnam Veterans Pow-Wow held in Oklahoma in 1982. Less elaborate linkage has been the "unofficial" referrals of minority veterans to American Indian medicine people, Hawaiian Kahunas, Chicano Curanderos, Asian healers, and other community "caregivers" network(Almond, 1974; Fuchs & Bashshur, 1975; Amoss, 1978).

Development of community and inclusion of traditional healing practices is an innovative, effective way of providing culturally relevant methods of therapy, improving the credability of formal programs in the local community and aiding the badly overworked personnel in the counseling programs established for Vietnam veterans.

It appears then, that while minority Vietnam veterans may in some ways get a double dose of psychic trauma, they may also have special cultural values or practices that can be valuable in coping with the psychological aftermath of their Vietnam experience. The clinician is encouraged to be innovative in developing community ties but to also keep the following recommendations in mind when working with minority Vietnam veterans.

First of all, it is crucial that the clinician has a clear understanding of the disruptive effect of psychic trauma on any individual. PTSD occurs <u>after</u> the trauma and often has prolonged, diverse effects. A therapist who has never experienced major

psychic trauma may have difficulty in comprehending the short and long-term effects of such trauma.

The clinician needs to have the ability to make an accurate differential diagnosis between PTSD and other problems such as depression or character disorders. Anger and hostility or a sleep disturbance can be indicative of several disorders so the precipitent and history of such problems is extremely important.

Second, the clinician needs to have a good sense of their own biases, prejudices, values and experiences; not only towards members of minority groups but also towards Vietnam veterans. The controversy over the war and the stance people took on the war, whether for or against, often has carried over to the present. In working with <u>any</u> Vietnam veteran, it is important for the clinician to "separate the war from the warriors." One of the drawbacks of a paper such as this one is that it groups <u>all</u> minority groups under one umbrella. It is absolutely important that clinicians do not make similar assumptions.

While there are many similarities between the experiences of people from minority backgrounds, there are also significant inter and intra-group differences which may affect the clinical picture. For example, amy Blacks may present in clinical situations with anger, hostility and suspicion(Lee, 1983) while American Indians may be quiet and expect the clinician to have a pre-existing idea of their issues(LaDue, Marcelley, & VanBrunt, 1981). Asian-

Americans may be extremely reluctant to disclose any type of problem(Sue, 1981) while other minority people may only answer questions in what they feel are socially acceptable ways. If the clinician is unaware of such subtle and overt differences, it is too easy to make an inaccurate diagnosis.

Clearly it is an enormous, if not impossible, task for any one person to have a working knowledge of all the subtlties and differences found in the myriad of racial and cultural groups in America, it is possible to avoid operating solely out of a stereotype and ones' own values. However, improved diagnosis of PTSD can occur if clinical assessment of minority Vietnam veteran is made by focusing on several dimensions: (1) the level of acculturation of the individual, i.e. how closely does the person adhere to either the traditional values of their group or the dominant values of the "majority" society; (2) the amount, type, and perception of discrimination and resultant difficulties faced by the person before, during, and after their military; and (3) the level of PTSD symptomatology presented by the veteran, i.e. how much of DSM-III criteria is present and how severe.

In final summation, the existence of PTSD is found in all humans exposed to psychic trauma. The presentation os symptomatology may differ from group to group as may appropriate therapeutic approaches. If the clinician is sensitive to the issues discussed in this paper, the liklihood of misdiagnosis of PTSD

may be lessened and invaluable support given to a very special group of people.

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